

Section 5 of 5

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Introduction

As therapists we wear many hats. With these hats come many roles, differing interpretation of these roles and high expectations. Our work is sometimes hard to define because we instruct volunteers, provide information to caregivers, and make reports to staff and peers. We lead support groups, programs and organize events. We raise funds, advocate for our clients and promote both our profession and the organizations we work for. Is it any wonder that we give the impression that we can attempt anything? I have observed that this image of diversity has resulted in us justifying our jobs, constantly educating others about our work and clarifying what we really do. It seems to me that depending on what philosophical foundation our employer has and what the financial climate is, we then focus our attention on one of the following three factors: clarifying our roles, demonstrating the value of our work or documenting the impact that we have made. As the nature of our work changes with multi-tasking and job definition, accountability is more of an issue than ever before.

It was this pressure that led me to the literature to find solutions to the problems facing our profession. As I explored the literature it became clear to me that I needed to be proactive to resolve these issues. Part of this process was the need to be clear about my contributions to the team, the amount of time it takes to articulate these contributions and how I actually communicated this information about my contributions. As I explored the literature I discovered concepts in the field of adult education that supported my thinking, and also gave me strategies that I could use in my practice. As I developed an understanding of, and an appreciation for, the links between therapy and education, I adopted teaching principles. To better understand these teaching principles and the similarities between the work of therapists and teachers we need to refer to the literature. In the literature, the processes of teaching and learning are grouped into several categories of influence or responsibilities. Each of these categories includes responsibilities for the learner, the teacher and the environment. In conceptualizing these roles for ourselves as recreation therapists, I suggest that you think of the "learner" as the client, the caregiver, volunteer or anyone who would be listening and responding to your instructions. The role of the "teacher" would be the recreation therapist as you define the job. The "environment" includes all of the components and dynamics of your place of work. The learner, the teacher and the environment participate and work together to increase satisfaction for everyone. This would be exemplified by the learner applying new strategies, the teacher observing and supporting the learner, and the workplace acknowledging and supporting the learning. To exemplify the interactions among the three variables, the learner, the teacher and the environment, I presented a visual analogy of a juggler with three balls. Two volunteers assisted in the demonstration. One individual recorded the audience's response to the question "What were the responsibilities of the three variables?" The second volunteer was a student who was taught the skills of juggling. This visual analogy gave the audience an opportunity to experience the variables in another sensory mode, observe modeling and participate in the articulation of the concepts. The results from the exercise were as follows:



Learner's Responsibilities

- to know what their needs are
- to be aware of their expectations
- to have questions
- to be informed of the content before attending the learning session
- to be willing to attend the presentation and participate fully
- to listen, think and concentrate on the presentation
- to reflect during the presentation as to how to use the information
- to be motivated
- to take risks

Teacher's Responsibilities

- to know the needs of the learners and of the workplace
- to know who the players are
- to know what the main issues are and what the stakes are
- to be enthusiastic
- to feel confident as an expert
- to take risks
- to be patient
- to be aware of different learning styles

Environment's Or Workplace Responsibilities

- to have clearly defined objectives and outcomes
- to be congruent with service delivery and education goals
- to be able to articulate the needs of all parties involved
- to provide a supportive environment for the exchange of information
- to inform all levels of administration of the content and process
- to be aware of the presentation level in relation to the audience
- to provide the necessary resources

Defining these responsibilities makes it easier to see the complexity of each of these variables. It is not difficult to see why or how some educational interventions fail, for that matter, how or why some of our therapeutic interventions fail. Since each one of these variables can be re-labeled as client, therapist, and the workplace. It seems evident that there are similarities in the way that teachers do their work and the way we do ours. Using the perspective of the recreation therapist as teacher, we can see that the responsibilities of the learner, the teacher and the environment provide a basis for choosing strategies that will increase the chances of our messages being heard and used. This exercise exemplifies the connections between teachers' and therapists' responsibilities as communicators of information. The relationships and outcomes seem to be parallel in promoting the exchange and use of strategies as a way of getting the job done.

Another point that I believe needs to be acknowledged is that each one of these variables is value laden. This compounds the very nature of each variable. How we think and behave is directly linked to what we believe to be true. The learner (client), teacher (therapist), and environment (workplace) is each part of the team. Each variable brings values, experiences, and issues to each situation.

This thorough discussion of the balls as variables has not brought into focus the role of the juggler. The juggler represents the concept of transfer of learning. Transfer strategies are the interventions that each of the three variables use to increase the probability of their message being heard and used. This is not to say that all of the strategies identified need to be used but, that an awareness and select use are necessary.



Clearly the degree to which each of the variables takes on their responsibilities significantly contributes to the juggler being able to juggle and not dropping any of the balls. Hence, the extent to which these variables are addressed will determine the degree of transfer of learning.

As a reader you may be thinking that, this is all very interesting. I know how complex my job is and I have a better understanding of the different roles in the process of learning. But I am not a teacher, I am a therapist. I do not have time to think or even do anything differently. I am overextended now, and the nature of my work is changing in such a way that more is going to be demanded of me. What does this really have to do with me? How can I use any of this information in a practical way? From my experience, when I invested the time and energy and used two strategies consistently, I was amazed at the significant difference it made in relation to the learners' use of information that I shared with them. Yes, I broke the rules in how I defined an educational intervention. The literature defines clear parameters around the definition of a learning setting or educational intervention. However, I see our work in the hallways, at the bedside, in team meetings and delivering programs as educational interventions. I believe that you do not need an hour to implement these strategies. I believe that you can implement any of these strategies as part of your work within five minute contacts. I have experienced that it does make a difference in how that learner/listener uses the information.

I would suggest that you begin by thinking about the specific place where you do your work. Think about how you do it and with whom. Then identify an issue. Examples might include, sharing resident information at a team meeting, training new volunteers, leading a support group for caregivers. When you have defined the "who", "what", "where" and "when", you then proceed to select from the following transfer strategies that best suits your circumstances.

Pre - Intervention Strategies

Take advantage of your perspective, acknowledging that you have expertise to share. Share your observations and opinions through objective measurable examples. **Example:** charting process, sharing at case conferences, sharing at team meetings. Make a conscious choice regarding your actions. Prioritize your actions. It is not possible to be in all places and do all things all the time. Determine who the key players are. Be sure these people have the facts. Create some "Hoop la" before a formal educational intervention. It is very important that a message of support be given by management to reinforce the significance of the training for the individual and team. **Examples:**

Familiarize the management with the content prior to the session. Encourage the content to be shared with all staff before the session. Offer training at a variety of times and dates to allow for maximum participation. Ensure information is distributed to all verbally and visually.

Distribute to all participants and management a self-assessment questionnaire prior to the event. How do I rate? (example Appendix 1) This will establish a baseline for evaluation. It will give direct feedback to the teacher, learner and management. This assessment will also provide an opportunity to stimulate self-reflection, critical thinking and expectations. This exercise also assists in self-awareness and enhances the concept of responsibility.

Work groups

It is essential that management be informed of the importance that learners attend educational sessions in their natural work groups. Work is not an individual activity. The result is that staff will support and reinforce each other as they work. They will naturally review and practice in the work setting what they have learned. They will more likely try new behaviors, be more observant of each other and compliment



each others work more. Morale increases with job performance.

Create Expectations

All participants involved need to be aware of and articulate their expectations. Expectations are directly linked to accountability and responsibility. If expectations are not clear, how can you know if you are meeting their needs or the needs of the organization.

Intervention Strategies

Rapport is key to the development of relationship and must be established quickly during the exchange of information. This can be done in numerous ways but should be done quickly so that sufficient time remains for conveying the intended content. Modeling as an instructional method is effective. Learners need to see, hear and experience a concept. A teaching principle articulated by Brundage & MacKeracher, (1980) is that facilitators model behavior that is relevant to the learners. Life-like situations can be included for discussion and analyzed by focusing on specific issues. This encourages learners to think of how they can use the information.

Mental Rehearsal

Imagine that Mrs. Brown did this, how would you use (select a technique) in reaction to the situation. This encourages reflection, critical thinking, expectation and responsibility. Over learning, or the repetition of content is crucial because it encourages mastery. With mastery comes confidence and this directly relates to the degree of later use. Learners have a need to experience and feel competence with new knowledge or skill before they actually use it.

Performance of the task is used to demonstrate and explain the nature or use of the concepts. Without this practice there is less chance that learners will use the information. **Example:** "Let's see you do it or give me an example as to how you would use this..."

Post Intervention Strategies

Trigger mechanisms are used when back at work to remind us of the learning situation. **Example:** These can be in the form of posters with statements of content, directions or reflections from the session. Follow up support is needed to refresh the learning or answer questions that occur after the learning event.

Example: This can be offered through the work setting or by negotiation can be provided by the trainer as part of the training package, (example Appendix 2).

Commitment validates the learner's experience and provides additional incentive to take responsibility. Ideally, the organization should actively support the individuals' responsibility for learning.

Example: Verbally reviewing content and stating commitment to the group as a closing activity, including commitment as part of the performance appraisal procedure, or writing a letter of commitment to yourself after the learning activity, (example Appendix 3)

Conclusion

Transfer of learning strategies are powerful tools that have the potential to impact our work positively. Through my research, I discovered that using only one or two of the stated strategies makes a difference. My hope is that through the exploration of these ideas, that you too discover the teacher within yourselves and try something new. Remember the words of Jack Canfield (personal communication, October 19,1993)" Those in life who succeed, take action."



Appendix A
A self-assessment tool
Therapists as Teachers

Please rate your current knowledge and understanding of the following topics related to adult education, training techniques and transfer of learning.

- Rating System:
- 1 - know nothing
 - 2 - am familiar with the topic
 - 3 - have a basic understanding
 - 4 - have fundamental knowledge of the concept
 - 5 - have extensive knowledge and understanding

Please circle the number corresponding to your answer

1.	Principles of adult education	1	2	3	4	5
2.	Strategies for pre-training	1	2	3	4	5
3.	Strategies for good training	1	2	3	4	5
4.	Definition for transfer of learning	1	2	3	4	5
5.	Definition of soft skills	1	2	3	4	5
6.	Strategies for evaluation, etc...	1	2	3	4	5

Appendix B
Follow up assignment
Therapists as teachers: Follow up food for thought

1. When you are back at work, share three of the most important things that you have learned with two people every day for one week.
2. The next time that you have to give instructions to someone regarding a task that they have to complete think about the process and implement at least one transfer technique.
3. Before you go to bed tonight, write down two things that you want to do differently when you go back to work.
4. When you return to your normal routines at work take time to reflect about the work that you do and give yourself credit for the great job that you do.

Appendix C
Commitment Letter

Date _____

Dear _____
(your name)

The most important things that I have learned at this symposium are ...

I plan to try the following things when I get back to work...

The most relevant things that I learned today from this session were ...

I plan to share this information with the following people...

I enjoy learning and discovering new things because...

(sign your name)



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WHEELCHAIR SPORTS AS SOCIAL INTERACTION

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Background

For over twenty years, I have worked in the fields of education and therapeutic recreation with people with disabilities. During this time, I have taken a keen interest in the areas of higher education, wheelchair sports, and social interaction. In higher education, I have observed an increased enrollment of people with disabilities in large enough numbers to command attention. At several municipal wheelchair tennis events, I have seen how social benefits can be gained by players with physical disabilities. Through participation, these adults, were able to acquire a sense of belonging, make friends, play with friends, find a forum for communication, learn new skills, and most importantly, acquire an opportunity to enjoy an activity. While most postsecondary institutions offer a wide array of intramural sports programs for able-bodied students, unfortunately, few advance wheelchair sports. By limiting opportunity, an avenue of social interaction for individuals with physical disabilities is blocked (Bedini, 1990).

Studies begun on veterans with disabilities by Guttmann (1976) at the Stoke Mandeville Hospital during World War II found that recreational sports played an important role in social rehabilitation. To show society that these veterans were not willing to remain hopeless invalids, as many in society believed them to be, Guttmann established the 1948 Stoke Mandeville Games. The games served two purposes: (a) to display sport, as not the exclusive right of the nondisabled society; and (b) to provide the idea of sport as an aid toward social restoration. Because of Guttmann's research, the idea of sports as an aid to social inclusion began to be explored by researchers such as Kennedy (1980), and Szyman (1980). They saw that social benefits can be gained through sports participation. Therefore, sport as a social vehicle, can provide a gateway to acceptance and social integration in the community.

Wheelchair Sports Within a University Setting

The word community, usually defined as a group of people living and/or working together in the same environment or location, takes on significant meaning in a university setting. In most university communities, the campus is composed of members of society bonded together by social norms, values, academic policies, and a mission. The major groups comprising a campus community are administrators, faculty, and students. They come to the university as members of society at large having been socialized into their society's values and biases. Thus, many bring with them already ingrained societal perceptions about people with disabilities.

Studies by Babbitt, Burbach, and Iutovich (1979), Turnbill, Raper, and Mesibov (1978), Babbitt and Thompson III (1981), explored how students with physical disabilities oriented themselves to college life. Several respondents in Babbitt's et al. study indicated that within the social context of college life attitudes have changed for the better. Many more, however, pointed toward administrators, faculty, campus service personnel, and peers without disabilities as seeing students with physical disabilities having an undesired differentness because of their impairment. Turnbill's et al. respondents found university staff showed a lack of personal concern, lumped all types of disabilities together, and offered a limited and inappropriate choice of sports programs. Babbitt and Thompson III, and Burbach and Babbitt concluded that the campus



environment continues to present many of the same social problems for students with physical disabilities that are found in the larger society. Thus, many times, students with physical disabilities arrive on university grounds only to find that their handicap sets restrictions on participation in many facets of campus life. One part of this life includes intramural recreational wheelchair sports activities.

For university students with physical disabilities to no longer be prejudged as different by the able-bodied campus community, they must receive support from that community in a setting that emphasizes ability and normality. Since administrators are the key links in their university's communication network (Burlingame, 1979), they play an important role in helping those students with physical disabilities overcome their social problems. Thus, the degree to which these students will be accepted and receive full educational benefits depends to a large extent on an administrator's ability to influence the hierarchy above and faculty below. It also hinges on how the administrator sees the needs of students with disabilities fitting in with the university's policies and mission. When attitudes of the able-bodied become more favorable, then programs that encourage social interaction can be considered.

Wheelchair Tennis

As administrators explore ways for increasing social interaction for students with physical disabilities, they need to weigh the beneficial effects associated with various intramural recreational wheelchair sports programs. Within such a program wheelchair tennis offers three opportunities. It is a sport that many people with a permanent physical disability can play. Even a class for those classified as quadriplegic is included. With assistance from a bandage applied in the shape of an 11811 to the hand and wrist that holds the racquet firmly in place, quadriplegics can hit most of the basic strokes. Because official game rules, bounded playing area, and single and double formats require no changes from regular tennis, the potential for increased play between those with and without disabilities is possible. The only rule exception is the two bounce stipulation. In wheelchair tennis, the wheelchair player is allowed two bounces, the first must land inside the court lines (Parks, 1988; Rafter, 1995). For players with a physical disability, these game factors can function as a social vehicle by displaying social ability and skill dexterity--not disability.

The number of people needed in a small group sport such as a wheelchair tennis game is two, or multiples of two. Direct interaction is enhanced due to only one existing channel connecting the two communicators/players. Therefore, in this dyadic situation. Highly complementary interactive relationships have a good chance of forming (Fisher & Ellis, 1990).

Summarizing, Pooley (1984) states that sports programs can make a definite contribution to improving the quality of life for any individual. This includes people with disabilities. However, on the university level, this can only be accomplished with the support and guidance of its administrators. Therefore, this study inquired whether administrators had given thought to wheelchair sports as a potential source of social interaction. To further explore this subject, this study examined their perceptions and responses regarding wheelchair tennis as a means of social interaction.

Theoretical Framework

Social theorists Georg Simmel (1950), George Mead (1962), Erving Goffman (1959, 1967), and George Homans (1950, 1958, 1961) sought an understanding of the distinctive character of interaction as it took place between human beings. Their theories provided the framework for explaining how wheelchair users can receive social interaction benefits through participation in wheelchair sports. This will be specifically illustrated through wheelchair tennis.

Simmers (1950) theory on the significance of numbers for social life examined combinations of



interactions among individuals within small groups. Using numbers, Simmel showed how a two-person group or dyad could fulfill certain interaction qualities for its members that larger gatherings could not. For example, dyads require the expenditure of a great deal of energy to keep a relationship going, and have a direct effect on each individual's opinions and needs. Thus, in a sport such as wheelchair tennis, the significance of a two-person relationship plays an important role. Without a common agreement that each two must cooperate toward achievement of the task, the game cannot be played.

Simmel's research influenced Mead's (1962) theory on Symbolic Interactionism. Mead saw symbols functioning as a communication medium, verbally or nonverbally. These symbols, which include body language and appropriate dress, tell two people how to interact with each other. Four aspects of interaction that Mead focused on were: How to keep the interaction going; if disrupted, how to manage to get it going again; the rules that govern those interactions; and interactions of considerable duration. Wheelchair tennis illustrates Mead's four points. The game is kept going by mutual consent of the players. The activity requires interaction between opponents and/or partners, and requires governance by its written and unwritten rules. These interaction factors heighten participation and enjoyment of actual play, and enhance symbolic identification for each participant.

Goffman (1959, 1967) created a dramaturgical model that detailed the social interaction roles people play in everyday social settings, one of which was the realm of sports. Goffman believed that games could show in a simple way the structure of real life situations. Games, like social life, have sets of rules that tell the players what should and should not receive relevance. The roots of a game, like society, lay in the interaction and controlled adherence to the rules. Thus, a game, like wheelchair tennis, has representative aspects of some parts of society.

Homans (1950, 1958, 1961) studied the social interaction of individuals by breaking down complex behaviors into simple components. Homans posited that the economic formula--profit equals reward minus cost--explained the underlying motives used by individuals continuously pursuing their goals in everyday life. Using wheelchair tennis to illustrate Homans' theory, the official game rules of wheelchair tennis are modified as little as possible from regular tennis. This increases the potential for recreational play between wheelchair users and able-bodied players. Perhaps then, an underlying motive for a wheelchair user wanting to maximize his or her potential for social interaction on campus would be participation in a wheelchair tennis activity. Joining for that participant might have aversive consequences as well. It could require too much expended effort in relation to the social reward received.

Organization and Management Theories

Like many institutions, universities have adopted various organizational principles of business management. These principles evolved from Taylor's (1911) Scientific Management, Follett's (1941) Human Relations Movement, and Weber's (1947) Neoscientific Approach.

Taylor (1911) believed that the workers in industry could be programmed to function as productively and effectively as the machines they operated. His approach to organizational management did not take into account the human aspects of administration such as mutual respect and teamwork.

Follett (1941) responded to the rigidity associated with Taylor's theory by stating that one supervisor should not give orders to a group of workers. Instead, all involved in a project ought to mutually be guided by the situation itself.

Weber (1947) saw bureaucracy as the key to a well-run administration. He also saw the dangers, however. Weber realized that the dynamics of organizational life could only be understood if in addition to the formal structure characterized by top-down authority and control, informal pattern of rules, groupings, and sanctioning systems were recognized.



The incompatibility between the three organization and management theories can be evidenced in the university's bureaucratic and professional administrative areas. Many times, administrators are forced to choose between their responsibility of executing the rules and policies of their organizations, or interest in their clients and professional authority stemming from expertise (Hoy & Miskel, 1996).

Federal Mandates

Legislation such as PL 90-480 the Architectural Barriers Act (1968), PL 93-112 Section 504 of the Rehabilitation Act (1973), and the Americans With Disabilities act (ADA) (1990) have improved physical access to university facilities and provided better educational opportunities for students with disabilities. However, these efforts are insufficient to constitute a barrier-free environment. Attitudinal barriers remain that still limit the social chances of students with disabilities.

The able-bodied campus community needs to remember that the fundamental importance of the university is not simply as an instructional site. The means of instruction needs to go well beyond the classroom. The university must represent a place that introduces its students to various views of the world and to particular social relations (Giroux, 1988).

Institutional Change

Recently, educators like Sergiovanni and Starratt (1993) have begun to help shift the vision of school toward a more enlightened supervision. The key component of this human resources approach is that administrators and teachers together make use of their experiences and creative abilities. Using this approach on the university level, the administrator's role then becomes that of an expediter; supporting, assisting, and sharing, rather than directing (Wiles, 1967). The administrator is now concerned with helping people to accept each other, by providing an open climate for growth and development, "eventually the improvement of society" (Burton & Brueckner, 1955, p. 88).

Starratt (1990) believed that people's insights and commitment are an organization's most critical resource. This is where the crucial link exists between formal goals and individual needs meet. This is where human requirements are served. For university students with physical disabilities to no longer be prejudged as different by the able-bodied on campus, they must receive full administrative support in a setting that recognizes their abilities and talents

Research Questions

Six research questions shaped this study. Collectively, they sought to uncover the direction and extent of university administrators' perceptions and responses toward wheelchair sports as social interaction, specifically inquiring about wheelchair tennis. These research questions included:

1. How are students with disabilities generally integrated into campus life?
2. Are there intramural sports programs for students with physical disabilities? If yes, what kind and what data is available?
3. Are administrators aware of the existence of wheelchair sports, and their potential for integrating students with physical disabilities into campus life?
4. Do administrators perceive socially beneficial effects from participation in a wheelchair sport such as tennis?
5. What do administrators believe the potential problems in setting up a wheelchair sports program are?
6. Are administrators familiar with federal mandates regarding the civil rights of students with physical disabilities?



Research Design

The literature collected for this qualitative study shaped the initial list of questions. An interview guide included further semi-structured and open-ended questions relating to each of the six initial research questions.

This study included within its sampling five universities, one located in the Midwest, four on the east coast. Three were private, two public. Of the five, Universities X and Y had intramural wheelchair programs, and Universities A, B, and C did not. In total twenty-five administrators were interviewed. They included vice presidents, directors/assistant directors, and admissions officers. Universities that did and did not have wheelchair sports programs were asked the same questions. This comparison gave the researcher deeper insight into contrasting administrator perspectives and responses.

Data was collected through a process of triangulation involving personal site visits where the researcher conducted in-depth interviews with administrators, observed on court wheelchair sports, and gathered existing documents.

The Findings

Findings to the six questions provided insights into the general concepts, specific ideas, and possible reservations that the twenty-five administrators had regarding wheelchair sports programs, specifically wheelchair tennis, as a means of promoting social interaction. Responses are summarized together below.

The Means of Integrating Students with Disabilities into University Life

Administrators at universities with wheelchair sports programs talked about community, teamwork, and networking in an effort to integrate students with disabilities into campus life. Their endeavors toward furthering inclusion expanded to finding new ways to collaborate and share resources such as staff and facilities. These administrators provided the kind of open climate that promoted growth and development for all members. They believed that their recreation centers played an important role in bringing all students, including those with disabilities, together. "This is a student recreation center; this is their building" (Interview, University X, Administrator 1).

A majority of informants at universities without wheelchair programs were so caught up in the bureaucratic aspects of their departmental responsibilities that they failed to see the human side of administration which builds community and trust. These administrators were not aware of any programs for wheelchair users, nor did they believe it part of their obligations.

The Kinds of Intramural Sports Programs Available for Students with Physical Disabilities

Half the respondents at universities with wheelchair programs gave the researcher documents showing the kinds of intramural wheelchair activities available for students with disabilities. Offerings included basketball, tennis, repelling, horseback and tandem bike riding. All held in high regard not only their wheelchair activities, but the variety of programs advanced.

Forty percent of the administrators at universities without wheelchair sports programs were not familiar with the kinds of extracurricular activities available to wheelchair users. In conversation with one administrator at a university with no wheelchair program, the issue of uncomfortable feelings came up. This prompted the researcher to ask other administrators whether there had ever been any discussions regarding faculty emotions toward students with disabilities. Five participants cited fear and societal misconceptions. Two examples follow: (a) an able-bodied student did not want to sit next to a student with a disability at a meeting for fear that the able-bodied students would label him disabled just by association, (b) an administrator stated that "They're perfectly free to go there (to a dance), but it's very difficult for a quadriplegic to dance, obviously" in response to a question regarding social activities on campus.



Awareness of Wheelchair Sports for Integrating Students with Disabilities into Campus Life

An interesting similarity between administrators at universities with and without wheelchair sports activities was that in the first group, one hundred percent held them in high regard, and in the second group, one hundred percent thought that having such a program would be a great idea. However, when the question of barriers getting in the way of continuation or their reaching fruition was asked, the following patterns emerged.

Owing to smaller numbers of participants in proportion to the able-bodied population, administrators at universities with wheelchair sports constantly had to justify this program's need and worth at budget time. Fifty percent of the administrators believed that these activities were an important quality of life component for wheelchair users. Therefore, they fought to keep them. "Students who have physical limitations should not be any less equipped, prepared, supported to accomplish their dreams" (Interview, Administrator 10, University X).

Regardless of the fact that one hundred percent of the participants at universities without wheelchair programs were open to the idea of a wheelchair activity, many stated that it was not feasible. Issues of not enough interest or resources, insignificant numbers, and departments working alone, were obstacles to program fruition.

Social Benefits Which May Result from Wheelchair Sport Participation

A majority of administrators in universities with wheelchair sports programs, 70%, as well as, those without such programs, 66.66%, recognized that sports activities contributed to social experiences. Their responses included friendship, integration, and social opportunity as high ranking social benefits. When it came specifically to wheelchair tennis, some administrators in both groups maintained that it offered communication, teammate interaction, and friendly competition. Only one administrator at a university without a wheelchair sports program had not thought about the social benefits that could be derived from sports participation, and that it was not an issue ever discussed.

Potential Problems That May Arise in Making Sports Available for Wheelchair Users

All respondents at universities with wheelchair sports programs indicated that their campuses and facilities were accessible. Many pointed out that students with disabilities did not need to identify themselves because accessibility was not a problem. One administrator emphasized the interdepartmental support and coordination that went into making sure that their campus was totally accessible.

At two universities without wheelchair sports programs, eight out of ten administrators believed that their campuses were in the forefront of accessibility. However, the five administrators at the third university would not state whether their campus was accessible or not.

When it came to liability exposure, five administrators at universities with wheelchair programs stated that it was not a problem. These informants communicated with risk management about what they were doing and about any new programs they were considering implementing.

At the three universities without wheelchair sports programs seven out of fifteen administrators had no idea whether having a wheelchair activity would increase their insurance costs. Four more weren't certain. One administrator believed that it would lower costs because those in wheelchairs do not get ankle and knee injuries.

Federal Mandates

All respondents at universities with wheelchair sports programs stated that they were familiar with Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Act (ADA) (1990). Most believed that regardless of these edicts, their policies and mission on including diverse groups in their university community and programs supported integration, and was just as important as the laws.

In those universities without wheelchair sports programs, twelve out of fifteen administrators stated that they were familiar with Section 504 and the ADA. The three that were not familiar with these mandates abruptly said so. Nine administrators also said that no special programs were offered to students with disabilities. One



administrator believed that it was enough that programs were offered to the general student body.

Conclusions

Based on an analysis of the data collected, a number of conclusions could be made about administrator perceptions and responses regarding wheelchair sports as social interaction. Administrators at the two universities with wheelchair sports programs exhibited characteristics of a community bound together by common interests, policies, and a mission. These common interests allowed colleagues to explore together innovative ideas, support ongoing programs, share meaning, and receive satisfaction from their work. While aware of their organizational responsibilities, these administrators, took a professional interest in their students, and shared in the responsibility of preparing them for productive and satisfying futures in a multi cultural society. These respondents imparted the feeling that they knew what schooling was really for, what it was about, and what primary purposes it did serve (Starratt, 1990). All seemed to have bought into the vision of what their universities were about. In fact, two specifically mentioned their founders and former presidents, whose visions helped shape present policies. Moreover, as one administrator stated we "are not operating in a vacuum." This was evident from the top-down, horizontal, and bottom-up flow of information between administrators, faculty, and staff. For these reasons, as several administrators stated, they could justify the need for continuance of their wheelchair sports programs.

Administrators clearly perceived sports to be an effective socializing agent for forming friendships and providing a forum for communication. Many spoke on a personal basis relating stories of friendships that have lasted a lifetime. Others saw it as a great esteem builder for those with disabilities. Further, administrators clearly understood Federal mandates such as Section 504 and the ADA. They emphasized that in spite of these laws, their universities had long histories of working with minority groups, including those with disabilities. These administrators believed that their universities would always include everyone, and that everyone's group belonged.

Administrators in universities without wheelchair programs revealed a lack of knowledge about activities for students in general, and for those with disabilities specifically. Five out of the fifteen interviewed stated that programming was not their area of responsibility. Several stated that their major concern was physical accommodations such as accessible ramps and parking spaces. While some did indicate a willingness to help in any way they could, the majority could be characterized as impersonal and insensitive toward others.

Eleven administrators did not have any knowledge nor were they certain whether a wheelchair sports program would increase liability exposure. Many, again, said that it was not their area of responsibility. Their responses demonstrated concern only with their specific obligations.

Interesting notes to this research were found in four different remarks at the end of the interview hour. At universities with wheelchair activities one administrator seemed glad that someone was looking into how administrators perceived students with disabilities, and the fact that eyes still needed to be opened. The other felt worried because five years from now there could be no guarantee that these programs would still be here. Many, such as the taxpayers and trustees, may not want to continue supporting a program they consider a luxury. One administrator at a university without a wheelchair program questioned why more students with disabilities were not attending, then wondered whether possibly there were more attending than realized. The other appeared saddened that opportunities for those with disabilities were limited, and felt that it was incumbent upon the able-bodied to help level the playing field in the future.



Recommendations

This preliminary study was intended to gather information on the perceptions and responses of university administrators regarding wheelchair sports as social interaction. In light of the findings, two recommendations for further research, and four recommendations for future practice were offered.

Further Research

1. Using the same set of interview questions, broaden the focus of the study by increasing the number and variety of subjects with and without disabilities.
2. Because their firsthand knowledge on wheelchair sports could prove invaluable for future qualitative or quantitative studies, employ administrators at universities with wheelchair programs as co-researchers.

Future Practice

Due to the lack of wheelchair sports knowledge exhibited by administrators at universities without these programs, provide in-service instruction on the subject. Such in-service instruction should offer exposure to the activities and the players with disabilities. This could start with a small group sport such as tennis. Holding the classroom on court could serve two purposes:

1. Increase awareness of the game, and two, reduce the fears and discomforts of administrators by putting them in contact with the wheelchair players. They could receive additional sensitivity training by actually sitting in a wheelchair and trying to rally the ball. This may not only increase their personal level of comfort, but better prepare them to give direct assistance to their students with disabilities.
2. Administrators at universities without wheelchair programs demonstrated that they could benefit from courses and/or in-service instruction in school law. Class(es) should include Federal mandates such as Section 504 of the RHA (1973), and the ADA (1990).
3. More than half the administrators interviewed at universities without wheelchair sports programs did not appear to comprehend liability issues in conjunction with such activities. A course that includes estimating liability risks and available resources on liability issues is important for them to have and understand.
4. As was evident from the interviews, many administrators tended to organize their perceptions and evaluations of students with disabilities around the impairment. They ignored the many valued aspects the student with a disability brings to the campus. Therefore, in-service workshops on topics relating to disabilities were suggested.

Summarizing, in many respects. Higher education poses as a last frontier in preparing young people for society. This preparation would be incomplete if they were not taught the deeper lesson of being human. As Babbitt and Thompson III (1981) stated "A university climate supportive of all its members requires the commitment of all its members" (p. 313). Therefore, the involvement of its administrators is crucial to maximize the ease and quality of social interaction on campus for students with disabilities. By being involved, a greater understanding, appreciation, and sensitivity of those students with disabilities may develop. If positive perceptions toward those with disabilities becomes an integral and ongoing part of the university, then responses to programs like wheelchair sports with resulting change in social interaction are likely to occur.



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ESTABLISHING PET VISITATION PROGRAMS

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"We are alone, absolutely alone,
on this chance planet,
and amid all the forms of life that surround us,
not one, excepting the dog,
has made an alliance with us"

Maurice Maeterlinck
"on the Death of a Little Dog"
from The Double Garden

The utilization of volunteer-based pet visitation programs adds a valuable form of service and therapy at minimum expense to the health care budget (Gallant, 1997). Many health care facilities are experiencing decreasing staff levels through downsizing and are facing increasing financial constraints. These factors necessitate a more cost-effective delivery of care which usually requires a better management of human and financial resources. Constraints have directed managers to explore more creative and less expensive means of providing patient care.

Animals have historically played many roles in improving the well-being of humans. The first recorded use of animals in a therapeutic setting was at the York Retreat in England, which was founded in 1792 (Katcher & Beck, 1983). Animals were used there in the asylums to "normalize patients" and to assist them in focusing on activities "outside of themselves." Now some 200 years later we continue to recognize the significant role which animals play in health care institutions.

"Pet visitation" is one term which defines the concept of pets visiting people who are hospitalized or who are residing in some form of a care facility. Other terms which describe a similar type of service include: animal facilitated therapy, pet therapy, and human-animal interaction. Arkow (1987) stated that such programs are "predicated upon the establishment of an enduring mutual support between humans and animals independent of other therapists ... the pet itself is the therapist."

Patients at an acute care center such as St. Paul's Hospital undergo a wide range of procedures and treatments during their stay. In addition to the more traditional health care practices, many patients also benefit from the therapeutic use of animals. Opportunities are created where patients can enjoy and benefit from pet visits at least several times per week. These visitations are coordinated through the joint efforts of the therapeutic recreation and volunteer resources departments, and in conjunction with British Columbia Pets and Friends, a non-profit society which facilitates programs involving "pets visiting people". Collaboration amongst various hospital departments and support from community agencies familiar with the specifics of pet visitations has contributed to the success of the program and also helped to minimize the potential risks associated with such programs.

Certainly the benefits of a well constructed pet visitation program outweigh the actual risks. Nonetheless it is imperative to ensure precautions are taken to minimize the likelihood of any negative occurrences. Potential problems can frequently be eliminated through the screening of animals and volunteers prior to them visiting patients and clients at facilities.

Screening is one method of preventing negative incidents from occurring. In BC Pets and Friends screens and orients volunteer teams in preparation for their pet visitation role. The society: ensures



vaccinations are up to date, screens temperament, orients the volunteer teams prior to commencing their visitation, provides liability insurance to visiting teams, communicates with volunteers through a newsletter and telephone contact, attempts to match agency needs to pet volunteer teams. For further information regarding pet precautions for visitation programs you may want to check with local veterinarians and review the current literature regarding Safe Pet Guidelines (Pets are Loving Support, 1995).

Once a volunteer team has been approved by BC Pets and Friends they are referred to a facility to begin their pet visitation role. The volunteer teams are usually oriented to their specific assignments by the respective health care agency's staff and the visiting then begins. There are presently over 300 "official" pet visiting teams throughout the Province.

Most of the "visitation teams" at St. Paul's consist of dogs and their human counterparts. Other facilities have enjoyed pet visits from other animals including: cats, birds, and rabbits. At St. Paul's, each visiting pet team has a number of specific units where they visit with patients, usually on a one to one basis. Patients in specific areas such as AIDS, Palliative Care, Rehabilitation, Geriatrics, and Psychiatry have frequently commented on the value of pet visitors.

A visit typically lasts for an hour. When a volunteer team is touring through a patient care unit they will walk through designated areas such as the wards, the patient lounges, and when appropriate the patient rooms. The volunteer will meet many patients, stopping for 2-5 minutes of chat and pats. Staff certainly appreciate a visit, too (Strickland, 1991). On other occasions a volunteer may be specifically requested to visit with a specific patient or number of patients who would benefit from a personal pet visit.

The benefits of such a program are widespread. Animals stimulate socialization among patients and between patients and staff (Barba, 1995). Pets act as social catalysts (Cusack & Smith, 1984; Thomas, 1994). They provide an enjoyable non-threatening medium to talk through, are non-judgmental, induce laughter, and make great listeners (Rossenkoetter & Bowes, 1991).

Interaction with these furry visitors has other benefits for hospitalized individuals which include improved: social interaction, psycho-social function, life satisfaction, mental function, mood, social competence, and psychological well-being (Francis, 1991). Research has also demonstrated that stroking and talking to animals seems to relax many people (Barba, 1995).

Pet visits benefit patients who experience any variety or combination of medical conditions including: depression, language and communication barriers, social isolation, social withdrawal, hospitalization stress, sensory deprivation, pain, and terminal illness (Gallant, 1997).

Those who currently or previously owned a pet certainly understand the important role they continue to play in our lives. As experience and research have documented, many patients with acute illnesses or medical conditions requiring hospitalization can continue to benefit from pet interaction while hospitalized.

For further information on BC Pets and Friends or St. Paul's Hospital's pet visitation program contact the author.

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MASTERS' PROGRAMS IN THERAPEUTIC RECREATION IN THE UNITED STATES

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In 1937, a call for the establishment of recreation therapy professional preparation arose from a conference held at the University of Minnesota. It was not until the late 1950's that there is found reference in the literature to the mention of master's programs in therapeutic recreation (TR), then termed "hospital recreation." Four such programs were identified (O'Morrow, 1983). In 1963, the Rehabilitation Services Administration became the first unit of the Federal government to recognize the need for such programs through its support of the establishment of university graduate programs in therapeutic recreation (Sessoms, 1970). This funding gave legitimacy to graduate-level preparation in TR and spurred the development of these programs.

These early efforts lead to the establishment of TR as a creditable area of graduate preparation. In 1990, Stewart and Anderson reported 45 TR master's programs were in existence in the United States. Nonetheless, within recent years several of the largest and best known master's programs have been closed. The loss of these programs was received with alarm by many in the profession and lead to the forming of a Task Force on Higher Education by the American Therapeutic Recreation Association (ATRA) to examine the situation. Research by the Task Force found that most of the remaining graduate programs were identified as an overriding concern (Compton & Austin, 1995).

The need to develop consistency among university graduate curricula in TR became apparent in the early 1970's and resulted in a curriculum conference, sponsored by the Bureau of Education for the Handicapped, an office then within the U.S. Department of Health, Education, and Welfare. This conference lead to the publication of guidelines for TR graduate curricula (American Association for Health, Physical Education, and Recreation, 1973). Even with this effort, consistency in university curricula has not been evident. Several years after the publication of the guidelines, Meyer (1980) decried the lack of consistency among university TR curricula. More recently, in a study by Hamilton and Austin (1992), national experts in TR echoed the need to develop consistency among university curricula. Further, these experts challenged the profession to more adequately prepare students for clinical practice. It is noteworthy to mention that the improvement of university curricula was one of two major areas (the second being unification of the profession) identified by the TR experts when asked what they would do if they could change anything in the profession.

In "Healthy America: Practitioners for 2005; A beginning dialogue for U.S. Schools of Allied Health," the PEW Health Professions Commission (1993) called for allied health professions to both define themselves and establish clear distinctions between levels of practitioners. Specifically, associate level,



bachelor's level and master's level practitioners should have clear distinctions related to training and tasks they can perform. The certification process established by the National Council on Therapeutic Recreation Certification (NCTRC) has focused on defining the role of the entry level therapist but offers no distinction for a master's level therapist (NCTRC, 1994).

Unfortunately, there currently is a lack of information on masters' training in TR profession. In order to address concerns springing from the American Therapeutic Recreation Association and noted authorities in the profession, as well as to answer the PEW Commission's call to establish clear distinctions between levels of training, a beginning point is to examine the current status of TR graduate programs.

This article reports on the findings of a mailed survey completed to determine the status of graduate education in therapeutic recreation in the United States and Canada. The research was completed at Indiana University and the University of Idaho under the auspices of the American Therapeutic Recreation Association (ATRA). ATRA commissioned this study, as a part of the work of the ATRA Academic Affairs Committee, in order to develop a basis from which to increase its support of TR graduate preparation. At the time, ATRA lacked data on the state of university programs and directions that ATRA might take to be supportive. The purposes of the study were to: (1) provide basic information on graduate programs in therapeutic recreation; (2) identify perceptions on accreditation, the health of programs, and areas needing strengthened; and (3) ascertain views as to how a professional society might assist colleges and universities.

Method

During the late spring of 1994, a survey instrument was developed to elicit information on graduate education in therapeutic recreation. Following field testing involving faculty at four universities, revisions were made. The final instrument consisted of 18 items designed to gain data on: (a) types of degrees offered; (b) number of credit hours required to complete the masters' programs offered; (c) types of masters' programs offered (e.g., emphasis, option, separate degree); (d) curriculum focus; (e) required TR masters' courses; (f) internships and other culminating experiences; (g) number of students enrolled; and (h) faculty characteristics. Additional questions related to accreditation, the health of programs, how programs might be strengthened, and respondents' views on how ATRA might support graduate education in therapeutic recreation.

The survey instrument was mailed to 150 colleges and universities in the United States and Canada identified by NCTRC as having professional preparation programs in therapeutic recreation. Two weeks after the initial mailing, a post-card reminder was sent to those institutions that had not responded. Finally, a second survey instrument was sent to nonrespondents six weeks after the initial mailing.

Results

Of the 150 institutions involved, 104 (69.3%) responded. Forty-three of these (41.3%) indicated that they provided graduate-level therapeutic recreation curricula. Data reported are based on these 43 programs.

Degrees

The largest number (33) of schools provided the Master of Science (M.S.) degree. Another 8 had the Master of Arts (M.A.) degree. A single institution reported it offered both the Master in Education (M.Ed.) and Master of Science degrees and another school stated it offered a Master of Special Education (M.S.E.) degree. Doctoral degrees were offered by nine of the masters' granting institutions, of these, four schools granted only the Ph.D. degree, two schools offered an Ed.D degree, two schools had both Ph.D. and Ed.D. programs, and one had both Ph.D. and Re.D. programs.



Credit Hours

The majority (36) of the 43 schools that replied used semester credit hours. The number of semester hours to complete masters' degrees ranged from 30 to 36. A total of 11 schools required 30 hours and 11 others required 36. The other 14 ranged between 31 and 35 semester hours. There were 4 schools that used quarter credit hours. Their required number of hours for the masters' degree ranged from 48 to 61 credits. No responses were provided by 3 schools.

Types of Masters' Programs

A total of 25 (58.1%) institutions identified their masters' programs as "emphases" (some course work in TR as part of a masters' degree). Another 15 (34.9%) described their programs as "options" (structured sequence of courses in TR in addition to the masters' core). There were two schools that identified their programs as "stand-alone" degrees (separate curriculum in TR) and one institution that indicated it offered a "separate degree" (specific masters' degree in TR).

Curriculum Focus

Of the 43 schools responding, 16 (38.1%) indicated their masters' programs were oriented toward both advanced clinical practice and management/administration. Another 14 (32.6%) schools stated their masters' programs to be primarily oriented toward management/administration. A total of 7 (16.3%) schools reported their masters' degree to be primarily oriented toward advanced clinical practice. Some schools (5 or 11.6%) reported other foci. These included: "scholarship--reflective practitioner," "applying research skills," "general TR and research," "first TR degree," and "individualized." one school stated it had no specific orientation.

Required TR Courses

Respondents were asked to provide a list of required TR courses at the masters' level. The most frequently required course was "Programming in Therapeutic Recreation," which was required by 22 (51.2%) of the reporting programs, other frequently required courses were: "Issues in Therapeutic Recreation" (required by 18 or 41.9% of the programs), "Leisure Education" (9 or 20.9%), "Assessment in Therapeutic Recreation" (6 or 14%), and "Therapeutic Recreation Intervention Techniques" (5 or 11.6%).

Internships and Other Culminating Experiences for Masters' Programs

Schools were asked if they required an internship as a requirement of their masters' program. A total of 16 (37.2%) stipulated a graduate internship was required for graduation. Of these 16 programs, 9 required only an internship, while 7 required both an internship and thesis. Another three schools reported that only the thesis was a graduation requirement but that students who were not Certified Therapeutic Recreation Specialists (CTRS's) were required to complete an internship. Still another school required either a thesis or professional project as a graduation requirement but indicated that any student who was not a CTRS had to do an internship.

A total of six programs gave their students the choice between completing an internship or thesis. Another five programs indicated they gave students the choice of completing an internship, a thesis or a professional project. A single program allowed students to either complete an internship or professional project.

Of the schools that did not include an internship as a requirement or option, there were six that required the thesis as a culminating experience. A single school required either a thesis or professional project and another school required a thesis or a comprehensive examination and six additional hours of course work. Finally, two institutions indicated neither a thesis or an internship was required. No



information was made available from one institution.

Students in graduate internships completed anywhere from 360 to 600 clock hours. The most frequent requirement (n=8) was 400 clock hours.

Numbers of Students

Only 26 (60.5%) of the 43 schools provided data on the number of graduate students in their programs. Numbers of full-time master's students ranged from 1 to 35. There were 6 master's programs with 10 or more full-time students. All other schools which reported had 9 or fewer full-time master's students. The four schools that reported full-time TR doctoral students had 9, 4, 3, and 2 students respectively. Numbers of part-time master's students ranged from 1 to 64. There were 9 master's programs with 10 or more part-time students. All other reporting schools had 9 or fewer part-time masters' students, only two schools reported having part-time doctoral students; one had a single student and the other had 15 part-time students.

Faculty

Respondents were asked to identify therapeutic recreation faculty by educational level, certification by NCTRC, and number of years of experience. A total of 122 full-time and part-time faculty were identified, with 80 being full-time and 42 part-time. Table 1 displays degrees attained and certification information for full-time faculty. Table 2 shows degrees attained and certification information for part-time faculty.

TABLE 1

Full-Time Therapeutic Recreation Faculty

<u>Degree Held</u>	<u>Certified</u>	<u>Non-Certified</u>	<u>Total</u>
Ph.D.	32	11	43
Re.D.	6	1	7
Ed.D.	12	3	15
Doc. (not specified)	2	1	3
ABD	1	0	1
Masters	10	0	10
Not specified	1	0	1
TOTAL	64	16	80

TABLE 2

Part-Time Therapeutic Recreation Faculty

<u>Degree Held</u>	<u>Certified</u>	<u>Non-certified</u>	<u>Total</u>
Ph.D.	1	2	3
Re.D.	0	1	1
Ed.D.	1	0	1
Doc. (Not specified)	0	1	1
ABD	1	0	1
Masters	25	4	29
Not specified	6	0	6
TOTAL	34	8	42



A review of Tables 1 and 2 reveals that 80% of full-time faculty and 83.1% of part-time faculty were nationally certified. Of the full-time faculty with terminal degrees, 62.5% (35 of 50) were certified. Only 2 of the 5 part-time faculty with terminal degrees were certified.

The number of years of experience in therapeutic recreation for faculty ranged from 2 years to over 30 years, with a mean of 15.13 years (SD=7.10). For full-time faculty the mean was 15.52 years (SD=7.44). Part-time faculty averaged 14.16 years (SD=6.20).

Accreditation

A total of 28 (65.1%) of the 43 schools responding reported that their undergraduate TR programs were presently accredited by the National Council on Accreditation of the National Recreation and Park Association and the American Association for Leisure and Recreation. When posed the question, "Do you feel graduate programs in therapeutic recreation should be accredited?" respondents were equally divided. Respondents favoring graduate level accreditation numbered 18 (41.9%), while those not favoring it numbered 18 (41.9%) as well. Another 7 (16.2%) did not respond to the item.

Health of Graduate Programs

Table 3 summarizes replies when respondents were asked to rate their graduate programs on a scale of "Extremely healthy" to "Terminal."

TABLE 3

Health of TR Graduate Programs

<u>Degree of Health</u>	<u>Frequency (percentage)</u>
Extremely Healthy	4 (9.3%)
Healthy	14 (32.6%)
Stable	20 (46.5%)
Ill	4 (9.3%)
Terminal	1 (2.3%)

Note. n=43

When asked to remark on factors affecting the health of their programs (either positive or negative), 38 (88.4%) of the 43 respondents provided comments. Those with healthy programs tended to emphasize having supportive administrators. Highly committed faculty, and a positive employment picture for graduates that lead to increased enrollments. Respondents from several healthy programs mentioned that NCTRC had produced an increased demand for graduate education since practitioners with undergraduate degrees were returning to school to upgrade their credentials. Those whose TR programs were less than healthy (i.e., "ill" or "terminal") tended to report a lack of administrative commitment to their programs and high faculty work loads.

Areas Needing Strengthening

A total of 32 (74.4%) respondents provided comments in an open response item about how their programs could be strengthened. The most frequently occurring were: "more clinical experience" (n=8); "more research" (n=7); "management/administration" (n=7); "master's-only courses" (n=5); and "assessment and/or documentation" (n=4). A review of additional comments showed a desire for more faculty, increased resources, and a greater number of TR specific courses. Several respondents indicated that curricular requirements leave little time for electives.



ATRA Involvement

Finally, respondents were asked to rank order from "most appropriate" (1) to "least appropriate" (5), five statements regarding ATRA's role in graduate education. Results are shown in Table 4.

TABLE 4
Rank Order of Statements Regarding ATRA Involvement Statement

		Mean	(SD)
1.	ATRA should aid graduate programs through information sharing and networking	1.97	(.89)
2.	ATRA should work with NTRS on accreditation practices already in place	2.07	(1.15)
3.	ATRA could best support master's programs through creation of standards/guidelines that graduate programs could use for self-study purposes	2.47	(1.08)
4.	ATRA should be practitioner focused and be distant from higher education	3.88	(1.24)
5.	ATRA should move toward independent accreditation of graduate programs	4.37	(.79)

Note. n=39

From a review of Table 4, it is clear that those participating in the survey believed it was least appropriate for ATRA to establish an independent accreditation program for graduate education and for ATRA to distance itself from higher education, on the other hand, those rating the responses avored ATRA facilitating information sharing and networking and, along with the National Therapeutic Recreation Society (NTRS), to work to strengthen existing accreditation practices. To a lesser degree, they favored ATRA supporting masters' programs through the development of standards/guidelines for self-study purposes.

Discussion

It was encouraging to learn that 43 institutions of higher education have masters' programs in TR since several universities have closed their TR graduate programs during the decade of the 1990's (Compton & Austin, 1995). This number (of 43) is similar to the reported number (of 45) masters' programs identified in 1989 (Stewart & Anderson, 1990). The reported relative good health of graduate programs was also an unexpected and encouraging finding, given the financial constraints under which many universities are operating today (Ridgely, 1993). It may be speculated that the health and stability of masters' programs may be related to the programs having faculty who average over 15 years of experience and who have over the years invested themselves in developing their graduate programs. On the other hand, having overworked faculty was perceived to lead to "ill" or "terminal" programs. From these findings, it appears that faculty play a key role, along with supportive administrators, in maintaining healthy TR masters' programs. These results are congruent with those of Austin, Hamilton and Jin (1995) who found healthy programs possess both committed faculty and supportive administrators.

It was positive to find 14 programs that emphasized management/administration since there has traditionally been a demand for those with management training. Another 16 programs claimed to emphasize both management/administration and advanced clinical practice. With most programs only 30 to 36 semester hours in length, however, it is difficult to envision how these programs were able to adequately focus on both areas. Only seven programs reported their masters' curriculum to be primarily oriented toward advanced clinical practice. When these results on the relative lack of focus on clinical preparation are combined with the finding that only 3 of the 43 programs were stand alone or independent programs in TR (i.e., not programs subsumed under park and recreation curricula which require courses in general recreation and do not allow for a high degree of specialization in clinical practice), a concern can be raised about the



small numbers of advanced or master clinicians being prepared. The finding that there are a relatively small number of programs that focus exclusively on clinical practice seems to be in conflict with Rancourt's (1986) suggestion that a master's degree is the appropriate degree for those functioning in clinical settings. Faculty apparently share concern over the lack of emphasis on clinical skills and knowledge since the most frequent comment on the open ended question of how to strengthen masters' programs was the inclusion of more clinical experiences. At the same time, almost as many respondents called for strengthening of the management/administration component so it is difficult to interpret these findings.

Other findings further revealed there has been almost no change over the years from the time of Meyer's (1980) charge of a lack of consistency among TR curricula. For instance, there was very little consistency in the TR courses taken by master's students as reflected in the diversity of course titles being offered at different universities. This is an area for future research and possibly for seeking increased consistency from program to program. Compton and Austin (1995), in a national study of TR programs, found that respondents favored curriculum revision as a means to improve the quality of university TR programs. How ATRA and other professional organizations can effect such changes is an area that merits examination.

The finding that only slightly more than one-third of the programs required a graduate internship brings into question whether masters' students are currently being given the opportunity to try out new understandings and skills during well structured and supervised practical experiences. There are obviously master's programs where students may not be given adequate opportunities under well prepared clinical supervisors to practice the advanced clinical techniques or the management skills they should be obtaining in graduate school. The necessity for such experiences has been emphasized in the TR literature for many years (e.g., Austin, 1974; Robb, 1973).

There was substantial agreement that ATRA should be involved in improving higher education programs and could assist colleges and universities to strengthen their masters' programs. An area of perceived importance for ATRA is to maintain structures for information sharing and networking (an area that the ATRA Academic Affairs Committee has pursued). Even though a split was found between respondents concerning the need for a graduatelevel accreditation program, respondents encouraged ATRA to work with NTRS on accreditation practices already in place. There was also some level of agreement that ATRA should develop standards or guidelines that graduate programs could apply in self-studies. Standards or guidelines for graduate education in TR certainly warrants further consideration and research effort.

In conclusion, survey data suggest that there are many positive signs today for TR masters' programs in the United States and Canada. These include the existence of approximately 40 relatively healthy master's programs being conducted by experienced and committed faculty with support from administrators. Alternately, there are a number of areas where program improvements may be made. In general, these include a perceived need for increased sophistication, and possibly greater autonomy, in TR masters' degree programs. More specifically, greater consistency in TR course requirements and internships would seem to be called for, along with increased concern for preparation for advanced clinical practice. There is a high level of agreement that ATRA can play a strategic role in efforts to improve masters' programs. Finally, it would seem that additional research is needed to further explore findings produced from our study. Perhaps it is also time for another curriculum conference similar to the one that lead to the American Association for Health, Physical Education, and Recreation (1973) guidelines for graduate programs in therapeutic recreation.



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MAKING AMERICAN ZOOS AND AQUARIUMS ACCESSIBLE

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In the United States, zoos and aquariums are places of recreation and education for millions of people. Attendance figures show that over 115 million people attend an American zoo or aquarium annually. This is more than the attendance of professional basketball, baseball, and football games combined for a year (Carpenter, 1992). It is interesting to note that of the known attendance at zoos and aquariums worldwide, 600 million people, or one-tenth of the world's population, make that visit in one year (Ross, 1997). Millions of people visit zoos and aquariums in a year, but are there people who are unable to attend? Does a disability prevent or hinder their ability to enjoy, learn, and impact the environment? Since 1990, all zoos and aquariums have been required to deal with the issue of accessibility. In that year, President Bush signed into law the Americans with Disabilities Act (ADA), which provides people with disabilities the most widespread civil rights protection ever. The law has the basic intention of eliminating discrimination and providing inclusive opportunities for people with disabilities.

Leading up to the development of this law, congressional hearings and reports revealed that:

- there is widespread discrimination against people with disabilities in housing, employment, and public services.
- nearly 43 million people (19% of the U.S. population) have some type of mental or physical limitation that affects their daily living skills.

The ADA is divided into five main sections or titles:

Title 1 concerns discriminatory practices in hiring procedures and employment. The law states that reasonable accommodations must be offered if an individual who is disabled is hired and needs those accommodations. Accommodations readily achievable include telephones with volume adjustment knobs for individuals with hearing impairments, larger print on documents or memos for those with visual impairments, and moving a desk from an inaccessible area to an accessible area for someone using a wheelchair. These accommodations must be made without significant cost or as designated in the law, being an undue burden to the employer.

Title 2, Subtitle A, prohibits discrimination by public entities against people with disabilities. Public entities are defined as state and local governments, some examples of which are park and recreation facilities, voter registration, and police and fire services. This encompasses all aspects of the entities' operations.

Title 2, Subtitle B, looks at the need for making public transportation accessible. These services include rail, buses, and vans.

Title 3, requires public accommodations and services operated by private entities to provide services to people with disabilities. One of the specific public facilities given as an example are zoos. (Private clubs and religious organization are excluded.) Areas that public accommodations need to make physically accessible include buildings; public transportation services; washrooms; parking areas; routes to and from a facility; and entrances to goods, services, programs, facilities, accommodations, and work areas. In addition,



new construction must be accessible. Facilities that are considered public accommodations may comply with the law through the use of auxiliary aids, services, removal of barriers, and modifications of policies, practices, or procedures.

Title 4 specifies the need for installation of a telecommunications relay service or a teletype writer (TTY). Individuals with speech and/or hearing impairments can then communicate with another person by a TTY or by a telephone relay system.

Title 5, is a miscellaneous section of the law that includes information on such items as insurance and other accessibility laws as they relate to the ADA. It is important to note that if a state law is more stringent than the federal law, the more stringent law is to be followed.

Since zoos are specifically mentioned under Title 3 and aquariums are implied, in 1990 there was a need to know their level of accessibility. To this end, a survey was designed and created by the author and experts from Illinois State University. It was then modified based on review by Brookfield Zoo staff and on comments from a pilot survey sent to nonprofit organizations similar in setup to zoos and aquariums.

The final version of this survey was sent to qualified members of the American Zoo and Aquarium Association (AZA) selected from the 1993 AZA directory. The criteria for inclusion in the study were that these members were in good standing, open to the public, and located within the United States. A total of 151 facilities met these criteria.

To ensure the highest number of completed questionnaires, the final instrument used the Dillman (1978) method of surveying, in which the survey form and a cover letter, along with a self-addressed stamped envelope, are followed up at 10-day intervals by a reminder postcard, a second survey and cover letter, and finally a phone call. With this method, 98 surveys (65%) were completed and returned.

The survey was divided into three sections. The first section asked basic background questions concerning each facility. The questions concerned the annual attendance, budget, the number of buildings, the number of full- and part-time staff, and the number of full-time and part-time staff that are disabled.

The second section asked questions about accessibility at the facility. These questions focused on the accessibility of programs for people with disabilities and the elderly, the use of auxiliary aids, guide-dog policies, advertising of services, and staff training.

The third and final section asked questions about the Americans with Disabilities Act. The questions asked if staff had attended some type of informational meeting on the ADA, if a key staff person had been selected to head up the efforts to meet ADA standards, if an advisory group or consultant had been used, if a barrier removal plan had been designed, which barriers had been recognized, and what factors limited the organization from removing those barriers.

The highest positive response rates came from facilities that had attended an informational meeting on the ADA (73%) and those that had selected a key staff person to be responsible for ADA compliance (70%). The other high positive response rate related to the adaptation of programs for people with disabilities (65%).

All remaining questions had a positive response rate below 50%. For other programming specifically designed for the elderly or a person with a disability, only 34% of respondents stated that they had specific programs for a person with a disability. The main programs offered included tours (34.5%), educational classes (20%), special days at the facilities (13%), and outreach programs (13%). Other programs were offered but reflected a much smaller positive response.

Only 40% of the respondents had a program designed specifically for an elderly person. The most frequently offered programs included a special day at the facility (23%), outreach programs (23%), educational programs (19%), and tours (15%). Other programs were offered but at a substantially smaller response rate, similar to the response rate for programming offered to people with disabilities. It is



interesting to note that these accessible programs were the same as the programming offered for people with disabilities.

Other questions within section two concerned auxiliary aids. The three auxiliary aids relating to a response rate above 50% were ramps (87%), wheelchairs (80%), and signage (54%). The remaining aids had positive responses of only 23% or lower. See Table 1 for frequencies and percentages of all auxiliary aids.

Table 1: Auxiliary Aids

<u>Types of Auxiliary Aids</u>	<u>Frequencies</u>	<u>Percentage</u>
Ramps	84	87%
Wheelchairs	78	80%
Signage	52	54%
Adult Strollers	22	23%
Elevators	19	20%
Large-Print Materials	18	19%
Accessible Trams	17	19%
Braille Materials	17	18%
Sign Language Interpreters	12	12%
TTY	9	9%
Motorized Scooters	8	8%
Assistive Listening Devices	7	7%

The responses to the question concerning staff training for assisting a person with a disability found that only 31% provided some type of training. More detailed questions were asked about full-time and seasonal staff training, how many attended, and if the training was mandatory or voluntary. If the training was required, only 26% of the full-time staff and 14% of the seasonal staff actually attended. If the training was voluntary, responses were slightly lower for full-time staff (22%) and slightly higher for seasonal staff (17%).

Section three concerned questions about the organization's efforts to comply with the ADA. The use of experts outside of the facility to assist with their accessibility also received a low response rate. Only 38% of the facilities had hired some sort of consultant to assist with their accessibility, with another 11% considering the same. Also, the formation of an advisory group had a positive response rate of only 33%. The establishment of a barrier removal plan or transition plan is explicitly written into the ADA. This plan is a written document that recognizes the barriers to people with disabilities, the projected date for removal of the barriers, the cost of removal, or recognition of the removal as an "undue burden." An undue burden is a factor such as cost or space that prevents the elimination of that particular barrier. Of the responses to the development of a barrier removal plan, only 44% had developed some type of plan.

Of the types of barriers recognized, the highest percentage recorded was some type of physical barrier (94%). These barriers included steep paths or ramps, uneven or rough sidewalks or pathways. High counters, steps, curbs, inaccessible walkway material, doorway problems such as narrowness, the poundage required to open doors, and difficult handles to grasp.

Problems with public amenities such as washrooms and parking were recognized by 38% of the facilities. Of the amenity problems, 79% had difficulty with restroom accessibility, 14% had a lack of accessible parking spaces, and 7% had a problem in both areas.

The next highest-rated barrier was signage (18%). Barriers to exhibits were recognized by 9% of the respondents. This problem focused on viewing into the exhibit. The remaining barriers included high public



telephones (6%). High food costs (3%), and long cue lines (3%).

Eighty-five organizations responded concerning factors that limited the removal of barriers. The largest limiting factor to barrier removal was financing (48%), followed by topography (12%) and lack of staff (8%). See Table 2 for the frequencies and listing of all limitations.

Table 2: Limitations to Barrier Removal

<u>Types of Barriers</u>	<u>Frequencies</u>	<u>Percentage</u>	<u>Cumulative Percentage</u>
Finances	41	48%	100.0%
Topography	10	12%	52.0%
Lack of Staff	7	8%	40.0%
Lack of Time	6	7%	32.0%
Retrofitting	6	7%	25.0%
Lack of Knowledge	5	6%	18.0%
Old Facility	4	5%	12.0%
Waiting on Superiors	4	5%	7.0%
Staff Attitudes	1	1%	2.0%
Other Goals	1	1%	1.0%

The survey results seem to indicate that zoos and aquariums are knowledgeable of the ADA because of the attendance of their staff at informational meetings and seminars. They have also made a good effort to select a key staff person to direct their accessibility efforts and adapt their programming for participants who have a disability.

The positive responses are then greatly reduced after those specific questions. Since finances seem to be a major deterrent to removing barriers at many facilities, it would seem logical that low-cost or no-cost methods to increase access would be employed. However, the hiring of consultants was used slightly more frequently (38%) than the formation of an advisory group (33%). Advisory groups usually are made up of people from the community who have a disability or people from an organization representing such a group.

These individuals usually help a facility improve access for free or for a nominal fee.

Another low-cost way of improving access is through staff training. Such training provides staff, especially those with much public contact, with information about different disabilities and teaches them to recognize potential barriers in their area of responsibility. Staff can provide potential suggestions for barrier removal or suggestions of alternative means of access.

It is interesting to note that many facilities with smaller budgets had many more services, staff training, and accessible amenities than facilities with larger budgets. See Table 3 for a ranking and percentages.

Table 3: Services Offered by Facilities with Budgets Below Mean

<u>Types of Services or Amenities</u>	<u>Percentages</u>
Designed Programs for the Disabled	75%
Barrier Removal Plan	70%
Adult Strollers	68%
Ramps	67%
Adapted Programming	67%
Training to Assist a Person with a Visual Impairment	67%
Training to Assist a Person with a Hearing Impairment	65%
Programming Designed for an Elderly Person	64%
Providing Motorized Scooters	63%



Training to Assist a Person with a Mobility Impairment	61%
Providing Accessible Transportation	59%
Provide Staff Training to Assist a Person with a Disability	54%

This survey provided the AZA with base-line information to assist its members with increasing the accessibility of their facilities and complying with the ADA. Some of the ways the AZA has helped its members include:

- sending its members an overview of the survey results, information on what the results mean, and information on ways to increase accessibility.
- discussions with the Department of Justice to modify service-animal laws to restrict them in areas in zoos and aquariums (see Appendix A). These discussions were the result of several incidences of animals aggressively trying to attack guide dogs and injuring themselves in the process. Some animals did die as the results of their injuries. Another topic of discussion was the prevention of physical contact between a previously quarantined zoo animal and an unquarantined service animal. This was meant to prevent the passing of illnesses or pests to the animal collection.
- sending updates on ADA regulations that affect zoos and aquariums. The ADA is continually being reviewed and modified. AZA members need to be aware of changes that affect them.
- providing conference speakers on ADA and access issues.
- referring questions on accessibility to appropriate sources.

Many zoos and aquariums are just beginning to address accessibility. Several others have worked to increase accessibility for many years. Brookfield Zoo has been involved in this process for over 20 years. To enhance the access of the zoo and to reach more people with its conservation messages, three main approaches are used.

First, the zoo's outreach program serves groups unable to visit the zoo because of the severity of their illness and/or disability. Small, mostly domestic animals are taken out for individuals to see and touch. Animal artifacts are also used in these presentations. No person other than zoo staff and volunteers can hold the animals. Each group is charged a modest fee to cover transportation costs. These parameters ensure that only the neediest groups participate in the zoo-sponsored program. If groups do not meet these restrictions they are then encouraged to visit the zoo.

If a group comes to the zoo, it is provided with "direct services." This approach includes prearranged, formal involvement by staff during the visit. This usually involves programs such as a hands-on tour in Children's Zoo. Specially trained staff, volunteers, and docents assist in these presentations. This prearranged tour is similar to the outreach program. Animals are brought out so the group can see and touch them. Again, no one except zoo staffer trained volunteers can handle the animals. Information on both the animals and animal artifacts is adapted to the level of understanding of the group. More variety in the types of animals can be shown to visiting groups.

The facilitation approach involves modification of zoo features and materials to provide inclusive opportunities without the direct involvement of personnel. These include:

- ramps
- wheelchair-accessible trams
- large-print and Braille Children's Zoo handouts
- large-print maps detailing accessibility information
- cutouts and statues of animals
- assistive listening devices for people who are hard of hearing
- easy-to-use interactives for all guests



- animal artifacts
- sign language interpreters who are available with prior notice viewing windows into exhibits

Additionally, the zoo keeps accessibility in mind while reviewing long-range projects and staff training. Information on accessibility is provided to assist planning teams to make new exhibits as accessible as possible. Also, information on different disabilities and how to assist someone with a disability is provided to new seasonal staff and new docents. Tentative plans call for this training to be included in training of new, full-time staff.

Overall, it appears that zoos and aquariums in America are aware of the ADA and accessibility for visitors with a disability. To answer additional questions and to ascertain if there have been any changes in accessibility levels, a second survey is being discussed for 1998. While some facilities still have a long way to go, overall they are making efforts to improve accessibility and appear to be heading in the right direction.

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Appendix A

The Application of the ADA to Zoos' Policies Concerning Service Animals

From the Department of Justice

Zoos and other facilities where animals are exhibited are subject to the requirements of the Americans with Disabilities Act (ADA). One of the underlying goals of the ADA is to foster the independence and self-sufficiency of individuals with disabilities. Service animals allow many individuals with disabilities to be self-reliant. Refusing to allow service animals in a place of public accommodation is not permissible under the ADA absent evidence that such animals pose a real threat to safe operation of the facility.

The ADA requires zoos and other facilities to make reasonable modifications to their policies, practices, and procedures when necessary to afford an individual with a disability the same goods, services, facilities, privileges, advantages, or other accommodations offered to others. Generally zoos and other facilities must permit the use of a service animal by an individual with a disability. Any limitations on the use of service animals in zoos and other facilities where animals are exhibited must be shown by the zoo to be necessary for safe operation.

Each facility needs to make its own analysis of its circumstances and the determination is very likely to differ from facility to facility depending on the types of animals and the configurations of the facility. Facilities that wish to restrict service animals in any way should make careful assessment of each area to determine where safety concerns justify restricting the access of persons with their service animals. Unsubstantiated fears about potential risks will not suffice to justify the exclusion of service animals from areas open to the general public.

It is not likely that a total ban of service animals from the entire facility can ever be justified. There are many zoo facilities that permit service animals in all or parts of their facilities apparently without problems.

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